STATE OF MONTANA FLEXIBLE SPENDING ACCOUNT
ENROLLMENT/CHANGE
AND SALARY REDUCTION AGREEMENT FORM (2008 BENEFIT YEAR)

Print name & address:

_____ _____ SABHRS ID Agency Name

_____ _____ Work Phone Home Phone

_____ _____ Social Security Number Date of Birth

1. ELECTION TO PARTICIPATE – Please check the box below to indicate the type of enrollment or change. I understand that I can only enroll mid-year if I am a new employee or I have a qualifying event.

☐ **New Employee**

The effective date of this Flexible Spending Account is the 1st day of the next **full month** after your health benefits are in force AND this form is received in the Health Care and Benefits Division.

☐ **Current Employee with a Change In Election due to a Qualifying Event**

Other enrollments or changes can only be made during a benefit year if they are consistent with an IRS allowed change in family status (marriage, births, adoptions, child support orders & losing other group coverage) that has occurred within the last 63 days. For Mid-year changes, the effective date is the 1st day of the next **full month** following receipt of form in the Health Care and Benefits Division. I certify that this enrollment/change is due to:

Qualifying Event: _____

Date of Qualifying Event: _____

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2. AMOUNT OF ELECTION - List the **Monthly Election Amount (including any unused State Contribution**) for your desired account(s). The minimum monthly election amount per account is $10.00 per month. Please elect an amount that can be divided evenly by two. **Your election will be rounded down to accommodate even deduction amounts if necessary.** A separate Administration Fee of $2.16 per month will be deducted automatically and should not be included in your elected amount.

*Remember "**Use It or Lose It**" – Set aside only as much as you think you will need. The IRS regulations require any unused contributions to be forfeited.*

PLEASE COMPLETE YOUR ELECTIONS

Monthly Election Amount *Make certain your election(s) are divisible by 2.*	
Medical Expense FSA *$10min/$416.66 max*	/month
Dependant Care FSA *$10min/$416.66 max* **(Day Care Expenses)**	/month
Administrative Fee	$2.16/month
Total Monthly Election	/month

I have read the informational material describing Flexible Spending Accounts and understand the participation conditions and requirements. I request participation in the FSA(s) listed above for the current benefit year, and authorize the State of Montana to reduce gross salary by the amounts indicated or in the event of self-paying to pay the amount indicated. I understand that my election amount will remain in effect for the entire benefit year, and only expenses incurred during period where contributions have been made can be claimed for reimbursement. I realize that this agreement **will NOT** continue for subsequent benefit years. This agreement revokes all prior State of Montana Flexible Spending Account Enrollment/Change and Salary Reduction Agreements signed by me for this benefit year.

Employee's Signature_____ Date_____

Administrative Use Only

FSA Type	Monthly Election	# of Months	Yearly Election	Election Period
Medical	_____ X	_____	=_____	_____ to December 31, 2008
Dependent Care	_____ X	_____	=_____	

Please return this form to: Health Care and Benefits Division, P.O. Box 200127, Helena, MT 59620-0127
A copy of this form will be returned to you by the Health Care and Benefits Division, confirming receipt of your election. (Revised 06/08)

Instructions

Maximum Elections Amounts – The maximum contribution for a **medical** flexible spending account is $4,999.92 per year per person.

The maximum contribution for a **dependent care** flexible spending account is $4,999.92 per year per household.

New Hire Effective Date - In the case of a new hire, the effective date is the 1st day of the month following the hire date. For example, if hired on March 15, 2008, the flexible spending deductions would not begin until April 1, 2008.

Mid-Year Enrollment – Mid-year flexible spending enrollment is only available to new employees within 31 days of employment. Please indicate the effective date of the election in the section across from the "Mid-Year Enrollment" box. The effective date must be the 1st day of the next full month following receipt of form in the Health Care and Benefits Division.

Change in Election– A change in your flexible spending election can be made in the cases where a qualifying event has occurred such as a marriage, birth, adoptions, pre-adoptions, child support order, losing other group coverage, death, or divorce. You must list the effective date of the election change located across from the "change in election" box as well as the event causing the change. Record the revised monthly election amount in the "Monthly Election Amount" section of the form. Please attach a copy of the appropriate documentation, which verifies the change such as marriage license or birth certificate.

Changes in election may also apply in the case of an unpaid leave of absence where an employee chooses (upon return to work), to revise the annual election amount.